

(b) CMS calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted copayment amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(c) To determine payment amounts due for a service paid under the hospital outpatient prospective payment system, CMS makes the following calculations:

(1) Makes the wage index adjustment in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the preliminary Medicare program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the copayment amount.

(i) The copayment amount for an APC cannot exceed the amount of the inpatient hospital deductible, established in accordance with § 409.82 of this chapter, for that year. For purposes of this paragraph (c)—

(A) Effective for drugs and biologicals furnished on or after January 1, 2001, the copayment amount for multiple APCs for a single drug or biological furnished on the same day will be aggregated and treated as the copayment amount for one APC.

(B) Effective for drugs and biologicals furnished on or after July 1, 2001, the copayment amount for the APC or APCs for a drug or biological furnished on the same day will be aggregated with the copayment amount for the APC that reflects the administration of the drug or biological furnished on that day and treated as the copayment amount for one APC.

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 per-

cent in calendar year 2006 and thereafter.

(iv) The copayment amount is computed as if the adjustment under §§ 419.43(d) and (e) (and any adjustments made under § 419.43(f) in relation to these adjustments) and § 419.43(h) had not been paid.

(5) Adds the amount by which the copayment amount would have exceeded the inpatient hospital deductible for that year to the preliminary Medicare program payment amount determined in paragraph (c)(3) of this section to determine the final Medicare program payment amount.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001; 73 FR 68814, Nov. 18, 2008]

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than—

(1) June 1, 2000, for coinsurance elections for the period July 1, 2000 through December 31, 2000; or

(2) December 1 preceding the beginning of each subsequent calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced coinsurance remains in effect unchanged during the year for which the election was made.

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined under § 419.32 or, in the case of payments calculated under § 419.43(h), not less than 20 percent of the APC payment rate as determined under § 419.43(h).

(f) The hospital may advertise and otherwise disseminate information

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concerning the reduced level of coinsurance that it has elected. All advertisements and information furnished to Medicare beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that coinsurance reductions are available only for hospitals that choose to reduce coinsurance for hospital outpatient services and are not allowed in any other ambulatory settings or physician offices.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001; 73 FR 68814, Nov. 18, 2008]

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) *General rule.* CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* CMS determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the “labor-related portion” of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.*—(1) CMS uses the hospital inpatient prospective payment system wage index established in accordance with Part 412 of this chapter to make the adjustment specified under paragraph (a) of this section.

(2) For services furnished beginning January 1, 2011, the wage index factor provided for in paragraph (c)(1) of this section applicable to any hospital outpatient department that is located in a frontier State, as defined in § 412.64(m) of this chapter, may not be less than 1.00.

(3) The additional payments made under the provisions of paragraph (c)(2) of this section are not implemented in a budget neutral manner.

(d) *Outlier adjustment.*—(1) *General rule.* Subject to paragraph (d)(4) of this

section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital’s charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of—

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under § 419.66.

(ii) At the option of CMS, a fixed dollar amount.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (d)(1) of this section is determined by CMS and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) *Limit on aggregate outlier adjustments.*—(i) *In general.* The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by CMS before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (d)(3)(i) of this section, the term “applicable percentage” means a percentage specified by CMS up to (but not to exceed)—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) *Transitional authority.* In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, CMS may—

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of